North Carolina Department of Health and Human Services
Division of Health Service Regulation
Mental Health Licensure and Certification
2718 Mail Service Center • Raleigh, North Carolina 27699-2718
http://www.ncdhhs.gov/dhsr/

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary

Stephanie Alexander, Chief
Phone: 919-855-3795
Fax: 919-715-8077

March 20, 2009

Dr. Frank Farrell, Center Director
O'Berry Neuro-Medical Treatment Center
400 Old Smithfield Road
Goldsboro, North Carolina 27530-8464

Re: Death Review Survey Conducted on 3/13-3/16/09
O'Berry Neuro-Medical Treatment Center , Provider# 34G004, 400 Old Smithfield Road,Goldsboro, North Carolina 27530-8464

Dear Dr. Farrell:

Thank you for the cooperation and courtesy extended during the death review completed 3/16/09.

An immediate jeopardy was identified during the survey. This resulted in the facility being out of compliance with §483.410 Governing Body and Management and §483.420 Client Protections. A plan was developed and implemented to remove the jeopardy on site.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practices that do not comply with regulations. You must develop a Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Condition Level W102 is listed condition level violation i.e. §483.410 Governing Body and Management.
- Condition Level W122 is listed condition level violation i.e. §483.420 Client Protections (W149).

Time Frames for Compliance

- A completed Plan of Correction addressing all cited deficiencies must be returned to our office within ten days of receipt of this letter.
- The condition level deficiencies must be ***corrected*** within 30 days from the exit date of the survey, which is **April 15, 2009**. You must request in writing a revisit indicating credible allegation of compliance no later than 30 days following the survey.
- If the facility is not in compliance at the time of the follow-up, a recommendation for termination from the Medicaid program will be made effective within ninety (90) days

from the last date surveyed.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Kimberly McCaskill at (919)855-3805.

Sincerely,

Kimberly C. McCaskill

Kimberly C. McCaskill, MSW, QMRP
Facility Survey Consultant I

Enclosures

Cc: dhsrrreports@ncmail.net
Carol Donin, State Operated Services
Monica Jones, DMA
Eastpointe Mental Health, Kenneth Jones
Wayne County DSS, Debbie Jones, Director
DMH/DD/SAS QM Team
Susan Politt, DRNS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G004	A. BUILDING _____ B. WING _____	C 03/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
O'BERRY NEURO-MEDICAL TREATMENT CENTER	400 OLD SMITHFIELD RD GOLDSBORO, NC 27530

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 102	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evident by: Governing body and management failed to: exercise operating direction and monitoring over the facility. Management failed to: provide adequate supervision to clients in group home 5-5 once the need had been identified by the management team in Cluster 5, ensure once staff were re-trained on supervision techniques in March, that all staff in group home 5-5 were consistent implementing the levels of supervision that clients required. This resulted in the neglect of client #1 (W104) The cumulative effect of this systemic practice resulted in the facility's failure to provide statutorily mandated governing body and management services to its clients.	W 102	The facility will ensure that managers and supervisors provide a safe environment for individuals in Group Home 5-5 daily by monitoring and supervising individuals according to supervision requirements, implementing active treatment programs and reviewing check sheets used by staff who document the status of individuals having time to themselves. See W104 for detailed actions.	4/15/09
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and confirmed by interviews with staff, the governing body failed to exercise general operating direction over the facility. This resulted in the inadequate supervision and neglect of client #1. The findings include:	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 1. Clients in group home 5-5 were not adequately supervised. Review included pertinent investigations involving supervision of clients residing in group home 5-5: a. On 3/16/09 a facility investigation, dated 2/12/09, was reviewed. According to the investigation a teacher for group home 5-5 walked into an activity room and found clients unattended. One of the clients required constant visual supervision. Neglect was substantiated and staff was re-inserviced on supervision levels of client in 5-5. The investigation noted a concern that staff was extending supervision of the activity room to the hallway on one side and the bedroom area on the other side. An in-service (signed by staff 2/27/09 through 3/10/09) regarding supervision for group home 5-5 was reviewed on 3/16/09. Document review revealed the in-service took place prior to 3/11/09, when the incident with client #1 occurred. Staff on all three shifts attended this in-service. According to the in-service, "Every fifteen minute checks only apply to personal leisure periods such as when an individual is not in a group setting such as their bedroom. Do not leave an individual or the group alone in the training (living) environment at any time...Monitor [Client #1] from a visual distance at least every fifteen minutes if she chooses to have time along..." b. On 3/16/09 another faculty investigation, dated 2/18/09, was reviewed. According to the investigation a client was without 1:1 attention per her plan. The client was in a recreation area with 4 other clients and only one staff.	W 104	1. In Group Home 5-5 by April 15, 2009 the following will be occurring a. During waking hours, staff will check on individuals every 15 minutes who have time to themselves away from staff and document these checks on the individual supervision check sheet. b. At night, during hours of sleep staff will check on individuals every 30 minutes. Documentation of these checks will not be required. c. A deviation from this model requires the Team's review with documentation by the Program Coordinator of the individual's supervision requirements in the Person Centered Plan. Theses supervision requirements will be reviewed at least annually and changed as needed. Staff will check on individuals according to the agreed upon supervision requirements and document these checks on the individual supervision check sheet as required. 2. The supervision requirements for each individual in Group Home 5-5 will be assessed by the team and any changes resulting from the assessment will be documented in the individual Person Centered Plan by the Program Coordinator no later than April 15, 2009. 3. During waking hours when individuals have time to themselves supervision checks are required. Rate and type of monitoring will be determined by the Team to ensure safety of the individual according to individual supervision requirements. (see 1c above).	4/15/09 4/15/09 4/15/09

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W 104	Continued From page 2 Interview with management staff on 3/16/09 revealed supervision had continued to be a problem so managers were encouraged to do unannounced walk-throughs of group home 5-5 at random times to ensure adequate coverage. When management staff was asked if this system was documented anywhere, staff stated, "No." 2. Client #1 was not provided adequate supervision. Review of a group home planner for 5-5 for C-shift revealed there was 6 staff working with 13 clients on 3/11/09. Review on 3/13/09 of client #1's physical therapy functional assessment dated 4/17/08 revealed she had a standard adult type wheelchair. It included a solid seat with a 2 and a half inch cushion, sling back, special seat belt (wider and with Velcro closure) a sling or hammock style footrest system and padded armrests. Further review of this evaluation revealed the footrest was modified for proper placing of her feet. "However most of the time as noted and reported, [client #1] prefers to sit with legs folded under her thighs. It is to be noted that overall wheelchair position is improved with this new, more appropriate wheelchair." Review of a health care personnel registry report dated 3/12/09 revealed client #1 was found unresponsive. She had slid down in her wheelchair and the seatbelt was across her neck. She was pronounced dead at a local hospital on 3/11/09. Review on 3/13/09 of a statement dated 3/11/09	W 104	a. The Group Home Manager or the Lead Developmental Technician II will make rounds to ensure client accountability, supervision and safety, and to monitor and document the completion of required check sheets. Documentation of this review will occur on the individual check sheet. b. On the days that the Program Coordinator or Cluster Administrator are present, rounds will be made to ensure client accountability, supervision, safety, program implementation and accuracy of individual check sheets. These reviews will be documented on the Group Home Log that is always kept at a designated location. c. The Administrator-On-Duty for the campus will make rounds in Group Home 5-5 at least once per shift in the evenings, nights, weekends and holidays to ensure client accountability, supervision, safety, program implementation and accuracy of individual check sheets. These reviews will be documented on the Group Home Log that is kept at a designated location. 4. Custom Adaptations will assess the status of all wheelchairs and check the appropriateness of seating for each individual in Group Home 5-5. Adaptations will be made as needed for individuals who slide in their wheelchairs. 5. The program team has already made necessary adjustments with client groupings, activity locations and staffing to ensure accountability and safety. The team will continue to review and address the Program Content schedule to ensure active treatment and the appropriate supervision of all clients in group home 5-5. This will be completed and in-serviced by the Program Coordinator and Special Projects Coordinator in Group Home 5-5 no later than April 15, 2009.	4/15/09 4/15/09 4/15/09 4/15/09 4/15/09

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W 104	Continued From page 3 by staff #14 revealed she took client #1 to her bedroom at approximately 5:40pm on 3/11/09. Further review of this statement revealed she then went to the dining room and assisted with feeding other clients. Further review of the statement revealed, "When the clients are in their bedrooms we usually all check every 5-10 minutes (sic). With client #1 we all know she likes to slide down so automatic we all know to keep checking on her." During interview with staff #1 on 3/13/09, she stated she was being interviewed by the cluster administrator (CA) in conjunction with an investigation on 3/11/09. Staff #1 came out of the CA's office and asked the other staff about client #1. Staff told her client #1 had not eaten yet, so staff #1 walked across the hallway to her bedroom and called her name. Staff #1 stated that she found client #1 slumped in her chair with her seatbelt around her neck around 6:45pm. She stated client #1's eyes were open and her lips were pale. Staff #1 called for assistance. Staff #1 classed to staff #15. Staff #15 was with a group that required visual supervision and could not leave her group, so she yelled for assistance. Staff #1 stated she slid client #1 down out of her chair in her bedroom and undid her seatbelt and staff #10 came into the room and started cardio-pulmonary resuscitation (CPR). During interview on 3/13/09, staff #1 stated they would check on client #1 because she would slide down in her wheelchair but she had never wiggled down this far before. Interview with nurses and medical staff at the facility on 3/16/09 revealed staff #10 called for assistance, a code blue was called, CPR continued in efforts to resuscitate client #1. The rescue squad arrived and client #1 was	W 104	6. Staff of Group Home 5-5 will receive training by April 15, 2009 on the following with signed rosters maintained by Staff Development: a. Best practices in communicating essential information when transferring client responsibilities from one staff to another will be in-serviced by the Special Projects Coordinator. b. "How to Be a Working Supervisor" training will be conducted by the Center Director or designee.	4/15/09 4/15/09 4/15/09

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W 104	Continued From Page 4 Transported to a local hospital where she was pronounced dead at 7:43pm. Review of a supervision inservice dated 2/27/09-3/10/09 revealed client #1 was to be checked every 15 minutes when she was away from her group. Observations at the facility on 3/13/09 and at 3/16/09 revealed staff had implemented a system of documenting when clients in group home 5-5 left their 2 groups (Group A and Group B) to go to other areas on the home. Per staff interview on 3/113/09 fifteen minute checks were not being documented prior to client #1's death. Following the death, the facility implemented the fifteen minute supervision checksheets. Review of these supervision checksheets on 3/13/09 and on 3/16/09 revealed staff were completing the sheets anytime a client in group home 5-5 left group A or group B to ensure staff were certain of client's exact locations in the unit at all times. Interviews with staff working in group home 5-5 on 3/13/09 and on 3/16/09 revealed some staff were not certain exactly how to implement the checksheets. Some staff thought they were only to be implemented at night, some staff thought they had to be implemented all the time and some staff was not certain this system was in effect. Interview with facility management staff on 3/16/09 revealed following client #1's death in group home 5-5 that the only system management put in place to ensure adequate supervision was the implementation of the fifteen minute checksheets. Facility management staff	W 104		

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W 104	Continued From page 5 Acknowledged there was confusion regarding the use of the checksheets.	W 104		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: The facility failed to: develop and implement procedures that prohibited the neglect of a client (W149). The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated services of client protections to its clients.	W 122	The facility will ensure that individuals in Group Home 5-5 will be safe from neglect by the following: 1. During waking hours, staff will check on individuals every 15 minutes who have time to themselves away from staff and document these checks on the individual supervision check sheet. 2. At night, during hours of sleep staff will check on individuals every 30 minutes. Documentation of these checks will not be required. 3. A deviation from this model requires the Team's review with documentation by the Program Coordinator of the individual's supervision requirements in the Person Centered Plan. Theses supervision requirements will be reviewed at least annually and changed as needed. Staff will check on individuals according to the agreed upon supervision requirements and document these checks on the individual supervision check sheet as required. See W149 for detailed actions.	4/15/09 4/15/09 4/15/09 4/15/09
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on observations, record review and confirmed by interviews with staff, the facility neglected to provide adequate supervision to ensure the safety of clients who resided in unit 5-5 after needs had been identified through investigations conducted within the last three months. The findings include: 1. Clients in 5-5 were not provided adequate supervision. Document review included pertinent	W 149	1. Staff of Group Home 5-5 will receive training by April 15, 2009 on the following with signed rosters maintained by Staff Development: a. The Cluster Administrator will ensure all staff have received the memoranda by Secretary Lanier Cansler "The Zero Tolerance for Client Abuse /Neglect/ Exploitation for Failure to Comply With Mandatory Reporting Requirements" dated February 4, 2009 and "Mandatory Reporting" dated February 24, 2009 b. The Special Projects Coordinator will train all staff on the "best practice" in sharing essential information when transferring client responsibilities from one staff to another.	4/15/09 4/15/09 4/15/09

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W 149	Continued From page 6 Investigations involving supervision of clients residing in group home 5-5: a. On 3/16/09 a facility investigation, dated 2/12/09, was reviewed. According to the investigation a teacher for group home 5-5 walked into an activity room and found clients unattended. One of the clients required constant visual supervision. Neglect was substantiated and staff was re-inserviced on supervision levels of clients in 5-5. The investigation noted a concern that staff was extending supervision of the activity room to the hallway on one side and the bedroom area on the other side. An in-service (signed by staff 2/27/09 through 3/10/09) regarding supervision for group home 5-5 was reviewed on 3/16/09. Document review revealed the in-service took place prior to 3/11/09, when the incident with client #1 occurred. Staff on all three shifts attended this in-service. According to the in-service, "Every fifteen minute checks only apply to personal leisure periods such as when an individual is not in a group setting such as their bedroom. Do not leave an individual or the group alone in the training (living) environment at any time...Monitor [Client #1] from a visual distance at least every fifteen minutes if she chooses to have time alone...." b. On 3/16/09 another facility investigation, dated 2/18/09, was reviewed. According to the investigation a client was without 1:1 attention per her plan. The client was in a recreation area with 4 other clients and only one staff. 2. Client #1 was not provided adequate supervision.	W 149	2. The supervision requirements for each individual in Group Home 5-5 will be assessed by the team and any changes resulting from the assessment will be documented in the individual Person Centered Plan by the Program Coordinator no later than April 15, 2009. 3. During waking hours when individuals have time to themselves supervision checks are required. Rate and type of monitoring will be determined by the Habilitation Team to ensure safety of the individual according to individual supervision requirements. a. The Group Home Manager or the Lead Developmental Technician II will make rounds throughout each shift to ensure client accountability, supervision and safety, program implementation and to monitor and document the completion of check sheets. Documentation of this review will occur on the individual Check Sheet. b. On the days that the Program Coordinator or Cluster Administrator are present rounds will be made to ensure client accountability, supervision, safety, program implementation and accuracy of individual Check Sheets. These reviews will be documented on the Group Home Log that is always kept at a designated location. c. The Administrator-On-Duty for the campus will make rounds in Group Home 5-5 at least once per shift in the evenings, nights, weekends and holidays to ensure client accountability, supervision, safety, program implementation and accuracy of individual Check Sheets. These reviews will be documented on the Group Home Log that is kept at a designated location.	4/15/09 4/15/09 4/15/09 4/15/09 4/15/09

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W 149	Continued From page 7 Review of a group home planner for 5-5 for C-shift revealed there were 6 staff working with 13 clients on 3/11/09. Review on 3/13/09 of client #1's physical therapy functional assessment dated 4/17/08 revealed she had a standard adult type wheelchair. It included a solid seat with a 2 and a half inch cushion, sling back, special seat belt (wider and with Velcro closure) a sling or hammock style footrest system and padded armrests. Further review of this evaluation revealed the footrest was modified for proper placing of her feet. "However most of the time as noted and reported, [client #1] prefers to sit with legs folded under her thighs. It is to be noted that overall wheelchair position is improved with this new, more appropriate wheelchair." Review of a health care personnel registry report dated 3/12/09 revealed client #1 was found unresponsive. She had slid down in her wheelchair and the seatbelt was across her neck. She was pronounced dead at a local hospital on 3/11/09. Review on 3/13/09 of a statement dated 3/11/09 by staff #14 revealed she took client #1 to her bedroom at approximately 5:40pm on 3/11/09. Further review of this statement revealed, "When the clients are in their bedrooms we usually check every 5-10 minutes(sic). With client #1 we all know she likes to slide down so automatic we all know to keep checking on her." During interview with staff #1 on 3/13/09, she	W 149	4. Custom Adaptations will assess the status of all wheelchairs and check the appropriateness of seating for each individual in Group Home 5-5. Adaptations will be made as needed for individuals who slide in their wheelchairs. 5. The program team has already made necessary adjustments with client groupings, activity locations and staffing to ensure accountability and safety. The team will continue to review and address the Program Content schedule to ensure active treatment and appropriate required supervision of each client in Group Home 5-5. This will be completed and in-serviced by the Program Coordinator and Special Projects Coordinator in Group Home 5-5 no later than April 15, 2009. 6. Staff of Group Home 5-5 will receive training by April 15, 2009 on the following with signed rosters maintained by Staff Development: a. Best practices in communicating essential information when transferring client responsibilities from one staff to another will be in-serviced by the Special Projects Coordinator. b. "How to Be a Working Supervisor" training will be conducted by the Center Director or designee.	4/15/09 4/15/09 4/15/09 4/15/09 4/15/09

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W 149	Continued From page 8 Stated she was being interviewed by the cluster administrator (CA) in conjunction with an investigation on 3/11/09. Staff #1 came out of the CA's office and asked the other staff about client #1. Staff told her client #1 had not eaten yet, so staff #1 walked across the hallway to her bedroom and called client #1's name. Staff #1 stated that she found client #1 slumped in her chair with her seatbelt around her neck around 6:45pm, She stated client #1's eyes were open and her lips were pale. Staff #1 called for assistance. Staff #1 called to staff #15. Staff #15 was with a group that required visual supervision and could not leave her group, so she yelled for assistance. Staff #1 stated she slid client #1 down out of her chair in her bedroom and undid her seatbelt and staff #10 came into the room and started cardio-pulmonary resuscitation (CPR). During interview on 3/13/09, staff #1 stated they would check on client #1 because she would slide down in her wheelchair but she never wiggled down this far before. Phone interview on 3/16/09 with staff #15 revealed on 3/11/09 she was involved in a meeting with the CA involving an investigation. After the meeting, staff #15 stated she would monitor the group while staff #1 was being interviewed by the CA and the advocate. She said staff #1 then went into the CA's office to be interviewed. When staff #1 came out of the office she walked out into the dining room and asked if client #1 had eaten yet. Staff #15 reported stated #1 said 'come here' and "that's when everything started." Staff #15 reported calling for help and stated "a lot of people came." Staff #15 reported she did not know client #1 was in her room and stated staff should tell someone if they put a client in their room.	W 149		

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	34G004	A. BUILDING _____ B. WING _____	C 03/16/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 149	Continued From page 9 Interview with nurses and medical staff at the facility on 3/16/09 revealed staff #10 called for assistance, a code blue was called, CPR continued in efforts to resuscitate client #1. The rescue squad arrived and client #1 was transported to a local hospital where she was pronounced dead at 7:43pm. During interview on 3/13/09, staff #17 stated she had witnessed client #1 sliding down in her wheelchair but staff would reposition her before she slid to her upper stomach. We reposition her when she starts "yelling". Review of staff #13's statement dated 3/12/09 revealed, "[Client #1's] normal routine would be to sit in a chair watching television or lay on her bed with the TV on. She would be checked every 15 minutes by the person who put her in the room, the one who was assigned to her or anyone who had heard her scream who check to make sure she was okay."(sic) Review of supervision requirements dated 2/27/09-3/10/09 revealed client #1 was to be checked every 15 minutes when she was away from her group. Observations at the facility on 3/13/09 and at 3/16/09 revealed staff had implemented a system of documenting when clients in group home 5-5 left their 2 groups (Group A and Group B) to go to other areas of the home. Per staff interview on 3/13/09 fifteen minute checks were not being documented prior to client #1's death. Following the death, the facility implemented the fifteen minute supervision checksheets.	W 149		

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W149	Continued From page 10 Review of these supervision checksheets on 3/13/09 and on 3/16/09 revealed staff were completing the sheets anytime a client in 5-5 left group A or group B to ensure staff were certain of the client's exact location in the unit at all times. Interviews with staff working in the group home on 3/13/09 and on 3/16/09 revealed some staff were not certain exactly how to implement the checksheets. Some staff thought they were only to be implemented at night, some staff thought they had to be implemented all the time and some staff was not certain this system was in effect. Interview with facility management staff on 3/16/09 revealed following client #1's death in group home 5-5 that the only system put in place to ensure adequate supervision was the implementation of the fifteen minute checksheets. Facility management staff acknowledged there was confusion regarding the use of the checksheets. On 3/17/09 the facility's policy, Reporting of Abuse, Neglect & Exploitation of Clients, was reviewed. The policy defined neglect as "Not providing goods or services necessary to maintain the mental or physical health of a client", including "Leaving a client who requires assistance unsupervised, placing them at risk." The Team on-site identified a situation of immediate jeopardy to the clients in group home 5-5. The immediate jeopardy was a lack of a sufficient process to adequately supervise the clients residing in group home 5-5, therefore putting them at increased risk. The facility was notified of the immediate jeopardy on 3/16/09. The facility was able to develop a plan on-site to	W 149		

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W 149	Continued From page 11 Remove the jeopardy to the clients which included the following: "Plan of Supervision and Monitoring to Ensure Safety in Group Home V-5" "Immediately beginning today we will begin to meet individually with each staff who works in V-5 and re-inservice them on the supervision requirements for the individuals who live there and the staff's requirements to document this monitoring. We will insure that each staff understands that the following changes are being made: 1. Monitoring checks of 15 minute intervals for all individuals in the home will begin immediately and this monitoring will be documented on the form that has been developed. 2. This monitoring will be done 24 hours a day 7 days a week until Executive management team determines it may be lessened. This will be no less than 30 days. 3. A Health Care Supervisor I or other management personnel will be present at all times on V-5. This manager will be responsible for continuously floating to ensure that the staff is in place are providing care and active treatment and are documenting the 15 minute checks. We are immediately placing (name of manager) there on C shift as the manager and moving the C shift health care manager to A shift. These managers will notate on the 15 minute checksheet that they have reviewed the monitoring information. If they find any problems with the log they will immediately contact the acting PC and CA and begin an administrative review that may lead to disciplinary	W 149		

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W 149	Continued From page 12 action. 4. A PC has been assigned to V-5 and is physically moving their office to this area and an acting CA has already been re-assigned and been physically relocated to the building. The PC and CA or other managerial staff will alternate hourly checks of the monitoring sheets. They will initiate a log to denote that they have completed this monitoring. Should any problems be identified, they will immediately notify the Deputy Director and the Center Director and an administrative review will be initiated. 5. Daily once in the morning and once in the evening, the QA officer, and the Special Projects Coordinator will personally come to V-5 and monitor the supervision and active treatment. They will look to ensure the individuals are properly supervised at all times and that documentation is in place. They will send daily reports to the acting CA. If they should see any problems they will immediately report them to the Deputy Director and the Center Director and administrative review will be initiated. 6. During the night on the A shift the AOD will come to the building hourly to review the documentation and also initial the checksheet. Should any problems be notified they will immediately call the CA to report the issue found. 7. All team members who work in this area will be tasked to review program content and make sure that it's effective and meets the needs of the individuals there. This will be completed in one week." This plan was reviewed by the team on-site. In	W 149		

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W 149	Continued From page 13 response to the immediate implementation of Steps 1 and 2, the immediate jeopardy was removed to the clients residing in unit 5-5. This plan was signed by the center director and the deputy director of the center on 3/16/09. Implementation of Steps 3 through 7 will be assessed during a follow-up visit within 30 days.	W 149		